

PATIENT ID: {HHRKUID}

AGENCY ID: {PDDIRID}

AGENCY NAME: {PROVNAME}

FORM \_\_\_\_ OF \_\_\_\_

{FORMNUM} {FORMTOT}

**MEDICAL EXPENDITURE PANEL SURVEY  
MEDICAL PROVIDER COMPONENT**

**HOME CARE EVENT BOOKLET  
FOR NON-HEALTH CARE PROVIDERS**

**FOR**

**REFERENCE YEAR 2000**

D1. During calendar year 2000, what was the (first/next) month during which your records show that services were provided in (PATIENT NAME)'s home?

MONTH: \_\_\_\_\_ YEAR: 2000

Month {EVNTBEGM}  
Year {EVNTBEGY}

D2. I need to know which type or types of persons provided services at (PATIENT NAME)'s home during (MONTH) and either the number of hours or the number of visits for each type.

OFFICE  
USE  
ONLY

TYPE OF PERSON HOURS/MINUTES: VISITS:

EXPLAIN IF NECESSARY: By type of person I mean a housekeeper, therapist, nurse aide, yard worker, and so forth.

Type of Person {HHTYPE#}  
Type of Person Description, Text {HHDES#}  
Type of Person - Hours {HHHOUR#}  
Type of Person - Minutes {HHMIN#}  
Type of Person - Visits {HHVIS#}

_	_____	_____ / _____	OR	_____	_ _
_	_____	_____ / _____	OR	_____	OFFICE
_	_____	_____ / _____	OR	_____	USE
_	_____	_____ / _____	OR	_____	ONLY
_	_____	_____ / _____	OR	_____	
_	_____	_____ / _____	OR	_____	

D3. I need a description of the services provided during (MONTH).

YES NO

Cleaning or Yard Work {CLEANING}  
Transportation {TRANSPRT}  
Shopping {SHOPPING}  
Emotional Support Person {ESUPPORT}  
Support Groups {SUPPTGRP}  
Child Care {CHILDCAR}  
Other {OTHRSERV}  
Other Specify, Text {OTSERVOS}

CLEANING OR YARD WORK.....	1	2
TRANSPORTATION.....	1	2
SHOPPING .....	1	2
EMOTIONAL SUPPORT PERSON OR ONE-ON-ONE BUDDY .....	1	2
SUPPORT GROUPS.....	1	2
CHILD CARE .....	1	2
OTHER (SPECIFY):		
_____	1	2

C2. What were the charges for the services provided to (PATIENT NAME) during (MONTH)?

**TOTAL CHARGES:** \$ \_\_\_\_\_.

**Total Charges** {TOTLCHRG}

C3. NOT ASKED THIS VERSION

C4a. Who paid your organization for the charges during (MONTH)?

a. Patient or patient's family \$ \_\_\_\_\_.

b. Medicare \$ \_\_\_\_\_.

c. Medicaid \$ \_\_\_\_\_.

d. Private Insurance \$ \_\_\_\_\_.

e. VA \$ \_\_\_\_\_.

f. TRICARE/CHAMPVA/CHAMPUS \$ \_\_\_\_\_.

g. Worker's Comp \$ \_\_\_\_\_.

h. Other (Specify):  
\_\_\_\_\_ \$ \_\_\_\_\_.

C4b. ASK FOR EACH SOURCE OF PAYMENT MENTIONED: How much did (SOURCE OF PAYMENT) pay?

IF NAME OF INSURER OR HMO, PROBE: And is that Medicare, Medicaid, or private insurance?

<b>Patient or Family</b>	<b>{PATPAYM}</b>
<b>Medicare</b>	<b>{CAREPAYM}</b>
<b>Medicaid</b>	<b>{AIDPAYM}</b>
<b>Private Insurance</b>	<b>{PINSPAYM}</b>
<b>VA</b>	<b>{VAPAYM}</b>
<b>TRICARE/CHAMPVA/CHAMPUS</b>	<b>{CHAMPAYM}</b>
<b>Worker's Comp</b>	<b>{WORKPAYM}</b>
<b>Other</b>	<b>{OTHRPAYM}</b>
<b>Other Specify, Text</b>	<b>{OTPAYMOS}</b>

C5. IF NOT VOLUNTEERED, ASK: And what was the total of all payments received for (MONTH)?  
[IF NOT AVAILABLE, COMPUTE.]

**TOTAL PAYMENTS:** \$ \_\_\_\_\_.

**Total Payments** {TOTLPAYM}

<b>BOX 1</b>	
<b>DO TOTAL PAYMENTS (C5) EQUAL TOTAL CHARGES (C2)?</b>	
YES .....	1 (D4)
NO .....	2 (C6)

C6. It appears that the total payments were (less than/more than) total charges. What is the reason for that difference? [CODE 1 (YES) FOR ALL REASONS MENTIONED.]

**Adjustment or discount**

Medicare {DISCARE}  
 Medicaid {DISCAID}  
 Contractual arrangement {DISCNT}  
 Courtesy discount {DISCRTS}  
 Insurance write-off {DISINSU}  
 Worker's Comp {DISWORK}  
 Eligible veteran {ELIGVET}  
 Other {DISOTH}  
 Other Specify, Text {DISOTOS}

**Expecting additional payment**

Patient or Family {EPAYPAT}  
 Medicare {EPAYCAR}  
 Medicaid {EPAYAID}  
 Private insurance {EPAYPINS}  
 VA {EPAYVA}  
 TRICARE/CHAMPVA/ {EPAYCHAM}  
 CHAMPUS  
 Worker's Comp {EPAYWORK}  
 Other {EPAYOTH}  
 Other Specify, Text {EPAYOTOS}

**Charity care or sliding scale**

Bad debt {SLIDSCA} {BADDEB}

**Payment more than charges**

Medicare {MORECARE}  
 Medicaid {MORECAID}  
 Private Insurance {MOREPINS}  
 Other {PAYMOTH}  
 Other Specify, Text {PAYMOTOS}

**PAYMENTS LESS THAN CHARGES: YES NO**

**Adjustment or discount**

a. Medicare limit or adjustment..... 1 2  
 b. Medicaid limit or adjustment ..... 1 2  
 c. Contractual arrangement with insurer  
 or managed care organization ..... 1 2  
 d. Courtesy discount ..... 1 2  
 e. Insurance write-off ..... 1 2  
 f. Worker's Comp limit or adjustment..... 1 2  
 g. Eligible veteran ..... 1 2  
 h. Other (Specify: ) ..... 1 2

**Expecting additional payment**

i. Patient or Patient's Family ..... 1 2  
 j. Medicare ..... 1 2  
 k. Medicaid ..... 1 2  
 l. Private Insurance ..... 1 2  
 m. VA ..... 1 2  
 n. TRICARE/CHAMPVA/CHAMPUS ..... 1 2  
 o. Worker's Comp ..... 1 2  
 p. Other (Specify: ) ..... 1 2  
 q. Charity care or sliding scale ..... 1 2  
 r. Bad debt ..... 1 2

**PAYMENTS MORE THAN CHARGES:**

s. Medicare Adjustment ..... 1 2  
 t. Medicaid Adjustment ..... 1 2  
 u. Private insurance adjustment ..... 1 2  
 v. Other (Specify: ) ..... 1 2

D4. Have we covered all of the months your organization provided services to (PATIENT NAME) during the calendar year 2000?

YES, ALL MONTHS COVERED..... 1 (D5)

NO, NEED TO COVER

ADDITIONAL MONTHS..... 2 (D1-NEXT  
 EVENT FORM)

**Yes, all months covered,**

**No, need to cover additional months**

{ALLEVNTS}

D5. REVIEW NUMBER OF MONTHS OF HOME CARE SERVICE REPORTED BY HOUSEHOLD. IF FEWER MONTHS OF SERVICE ARE REPORTED BY THE HOME CARE ORGANIZATION, PROBE TO EXPLAIN THE DIFFERENCE.

NO DIFFERENCE OR PROVIDER REPORTED MORE MONTHS OF HOME CARE SERVICE THAN HOUSEHOLD ..... 1 (D6)

PROVIDER RECORDED FEWER VISITS:..... 2  
PROBE: (PATIENT NAME) reported (NUMBER) months of home care service. Do you have any information in your records that would explain this discrepancy?

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D6. GO TO NEXT PATIENT FOR THIS PROVIDER.  
IF NO MORE PATIENTS, THANK THE RESPONDENT AND END THE CALL.